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17 April 2010

NPA hot seat up for grabs again

Chief executive quits

Where next for the trade body?

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> A FEDERATION MODEL WOULD SURELY PRESENT A TOUGHER PROPOSITION WHEN IT COMES TO ARGUING THE TOSS WITH THOSE HOLDING THE SECTOR'S PURSE STRINGS

The office phones had been ringing for a few days before the official announcement finally came, but it was still a surprise when the NPA revealed late last Thursday that its chief executive John Turk had resigned (p4).

To lose one chief executive in eight months (Mr Turk's predecessor) could be considered unlucky but lose two in three years and it's not surprising that questions are being asked.

Chairman Ian Facer – who to his credit was prepared to speak to C+D this week – was adamant that the organisation would not be derailed by John Turk's departure. It would continue to strive ahead with its stated aim of representing, supporting and protecting its members, he reassured us.

Now there's nothing wrong with these objectives but, with the pharmacy and political landscapes changing fast, are they enough of a USP to ensure the sector gets the trade body it deserves?

Take a look at the websites of some of the big pharmacy organisations and you'll see there's an unsurprising degree of commonality about their aims and objectives.

Whether it's the CCA, PSNC, the PDA or the new professional leadership body, to name but a few – contractors, locums, and employees will find that there are any number of representative and supportive groups working on their behalf.

A successful thriving pharmacy profession benefits everyone and, as our analysis (p10) suggests, there may be another option to help achieve this, but one that some may find unpalatable.

With more than one pharmacy organisation now claiming to represent pharmacy in some shape or other, it begs the question whether the sector would be better off adopting a federation-type model.

Former NPA chief executive John D'Arcy believes this could take the form of an umbrella organisation speaking for pharmacy as a whole but with the individual bodies sitting underneath it representing their members' views.

Much like the successful BMA model adopted by our medical colleagues, a federation model would surely present a tougher proposition when it comes to arguing the toss with those that hold the sector's purse strings.

We've watched our GP colleagues struggle with a raft of reforms over the past decade but they've emerged with a contract that most bankers would be happy to have, no weekend working and a reputation among patients that is still second to none.

This is not to say that a federation model would necessarily be the answer for pharmacy, but it's a plan worth considering.

Gary Paragpuri, Editor

NPA defiant over its future as another chief executive quits

"We won't fall over," says chairman, following John Turk's surprise departure last Thursday

Zoe Smeaton
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The National Pharmacy Association's (NPA) chief executive John Turk has resigned from his role, the association has announced.

The NPA said Mr Turk had "resigned to pursue other projects", although it could not comment on what those other projects might be.

Mr Turk's departure means the association has lost two chief executives in just over two years after former chief executive Alison White left in January 2008.

NPA chairman Ian Facer thanked Mr Turk for his contribution over the past two years, but admitted to C+D that losing two chief executives so quickly was "not ideal". However, he said the association was well equipped for the future and it would be business as usual until a new chief executive was found.

"It's not ideal, but that's life – whatever organisation you work in people come and then further down the line their ambitions change and unfortunately that is what has happened to the NPA," Mr Facer said.

He added that the board would discuss finding a new chief executive when it met towards the end of the month. In the meantime he said staff were clear on what they needed to do and where the organisation was headed for the rest of the year. "We're not going to fall over because there is no chief executive. Clearly if we still don't have one in 2011, I might be a bit more concerned but I'm sure people will be queuing up for the role," Mr Facer said.

Asked if Mr Turk's departure had been discussed by the NPA board prior to his decision Mr Facer responded: "Why would it be?"

Mr Turk said on his departure: "I feel that I have achieved a great deal during my time at the NPA. The organisation now has a clearly defined remit to represent, support and protect its members and a strong management team and structure in place to deliver."

John Turk: pursuing other projects

NPA gives restructure update

The NPA is reaching the end of its restructuring programme, including four redundancies, and now has a clear remit – to support, protect and represent pharmacy owners – chairman Ian Facer has told C+D.

Mr Facer said the restructure was almost complete, although the association confirmed it was still in consultation on making the four people in its communications directorate redundant.

The NPA will now target greater member feedback. It is also in dialogue with the Co-operative Pharmacy, which left the NPA last year after choosing not to renew its membership, Mr Facer said.

Mergers with other organisations such as the CCA were also not completely ruled out, as Mr Facer told C+D if there was a better way for the NPA to "beef up" its representative role it would "look at it". **ZS**

NPA CEOs since 1996

John D'Arcy
Reign: 10 years and five months from 1996 to 2007
Highlight: helped pharmacy start punching its weight on the political scene, telling MPs who complained the sector was over-represented that it was "none of their business".

Alison White
Reign: seven months from June 2007 to January 2008
Highlight: called on the health secretary to end "boom and bust" funding, saying: "Please, Mr Johnson, make your next announcement on pharmacy really count."

John Turk
Reign: one year and 11 months from April 2008 to March 2010
Highlight: defending contractors on stock shortages, saying manufacturers thinking they could control the supply chain was "complete and utter bollocks".

Your views

"Perhaps this is a new opportunity for the NPA. The next chief executive needs to decide what the NPA's role is. I would like to see a next chief executive who understands the profession and the challenges [the sector faces]." **Fin McCaul, Prestwich Pharmacy, Manchester**

"I am sorry to see John Turk go. He was quite an outspoken chief executive who said what he felt." **George Romanes, Romanes Pharmacy, Scottish borders**

"John had done quite a lot to change the way the NPA worked and it was going quite well." **John Goes, JP Goes Pharmacy, Coventry**

"The resignation of John Turk is welcomed. This should be seen as an opportunity for the current boards of the NPA, PSNC and PLB to put their differences aside and explore opportunities of working together." **Salim Jetha, chief executive, Avicenna**

Is it time for the NPA to merge with another pharmacy body?

See analysis p10

EPS 2 rollout could start from May, says supplier

Shortage of GP test partners has delayed technology, experts reveal

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Systems accredited for the final stage of the electronic prescription service (EPS) could be ready for national rollout to pharmacies from May, a system supplier has estimated.

But suppliers warned C+D this would depend on approval from Connecting for Health, and said they continued to be frustrated by the agency's slow progress on EPS.

Simon Driver, managing director at Cegedim Rx, said the company's Pharmacy Manager system was now being tested by more than five pharmacists who were receiving prescriptions electronically from GPs under EPS release 2.

"The latest is that we are finally at the number of scripts that we have to go through and we should now go for our sign off. This will go through a number of boards but we hope we're going to get it by about the end of May," Mr Driver told C+D.

He added that the process had taken "far far longer" than he had expected. However, he said he felt that the agency had done "a good job" in testing the system thoroughly, and added that pharmacists had been surprised by how easy release 2 had been to use.

Good feedback on release 2 from pharmacy pilots, but GP links slowing progress

Ian Taylor, commercial director at Rx Systems, said the company now had three pharmacy sites live on the system but that Connecting for Health had struggled to find them GP sites to pair with, which was slowing progress. "Connecting for Health is very slow – it's ridiculous that we can't find pairings."

A Connecting for Health spokesperson said: "Initial implementation of EPS release 2 is an ongoing activity with three dispensing systems having approval to use live patients. There are currently 12 pharmacies enabled to use EPS release 2."

Will EPS release 2 make your job any easier?
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AAH hits out at government inaction over drug shortages

Wholesaler AAH has blasted the government for failing to go far enough over the stock shortages crisis.

In a question and answer session at the Avicenna Conference in Kerala, AAH sales director David Rollinson called for further investigation into the root causes of the problem.

He said: "The government hasn't looked into what's causing shortages or quotas. We need to look at what's doing it."

Asked if pharmacy minister Mike O'Brien could solve the crisis, Mr Rollinson added: "The minister has the power, whether he chooses to use it is up to him."

However, speaking exclusively to C+D, Mr O'Brien said the government had taken action to resolve the problem, citing parallel exports as a "major problem" that was being caused by a "small number of unscrupulous people".

The government had already held a summit to tackle stock shortages last month (C+D, March 13, p7) but there was no room for complacency, Mr O'Brien said.

The pharmacy minister went on to praise pharmacists' efforts to get hold of key medicines during the supply problems.

He said: "I want to recognise the extra workload [for pharmacists]." And added: "It's too early to say we're on top of it, but I hope the new measures will be enough." **CC**

...coverage of the election ... with a review of 20 years ... pharmacy policies and we talk ... Tories' pharmacy minister
... page 24-28

In brief

First GPhC Council

New pharmacy regulator, the General Pharmaceutical Council, was due to hold its inaugural public council meeting as C+D went to press. The meeting agenda included establishing rules over council member's expenses.
www.chemistanddruggist.co.uk

New super at Lloyds

Steve Howard has replaced Nick Mortimer as superintendent pharmacist at Lloydspharmacy, the multiple has announced. Mr Mortimer took the decision to leave as part of a Lloyds head office restructure earlier this year.
www.chemistanddruggist.co.uk

NCSO update

The DH and National Assembly for Wales have agreed to allow NCSO endorsements for the following for April prescriptions: calcitriol 500mg capsules, diltiazem 60mg modified-release tablets; and sulfinpyrazone 100mg and 200mg tablets.

Hayfever boom

Over 30 million people in the UK could be affected by hayfever by 2030. The rise would be triggered by a boom in Britain's urban population, said the report from the director of the National Pollen and Aerobiology Research Unit.

Treatment combo safe

Proton pump inhibitors are safe in patients prescribed antiplatelet drug clopidogrel, researchers from the University of East Anglia have found. The findings follow an ongoing safety review by the US Food and Drug Administration.
www.chemistanddruggist.co.uk

Murray the man for CCA

The CCA has appointed Murray Duncanson as its new chairman. Mr Duncanson has held a number of senior managerial positions in the NHS, including chief executive of Barnet Healthcare NHS Trust.

Avicenna falls service

Avicenna is set to launch a national falls prevention campaign tailored specifically for independent pharmacists. The service will launch on June 21 to coincide with National Falls Awareness Week.

Qualifying hurdle for Scottish contract bids

Government proposals aim to cut time-wasting pharmacy applications

Max Gosney
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Bids for new pharmacy contracts could face a pre-qualifying test before being judged by NHS boards in Scotland.

The move aims to weed out time-wasting applications and comes as part of proposals to overhaul control of entry in Scotland. Existing rules drain resources as boards sit to hear all applications even if similar bids have already been refused, the Scottish government (SG) said.

The SG wants to reduce costs by granting boards greater powers to pre-screen applications. This could mean applicants having to show what has changed since a previous bid was refused.

The SG said: "If a first stage in the process was introduced, this should remove the necessity for the establishment of a full Pharmacy Practices Committee for every application, particularly those where application(s) have been made in the past."

The proposals are open to consultation until June 11.

Other key changes to control of entry under discussion include:

- dispensing doctors to be told of any pharmacy application made in the area they operate
- shake up to the structure of the National Appeal Panel including reducing the number of panellists
- applications under minor relocation must show "no significant effect" from the change rather than the current "no appreciable effect".

Consultation in full at **chemistanddruggist.co.uk/news**

An Aberdeenshire pharmacy shows off its aqua shades, which form part of a redesign bid to convince more patients to access NHS services at the premises. The overhaul, by design firm Dollar Rae, includes a robot that dispenses completed prescriptions to the counter in 10 seconds. An extended consultation area at the Inverurie pharmacy has also been added to allow travel health clinics, cholesterol testing and EHC. MG

In brief

Lloyds eyes staff

Lloydspharmacy is holding events for locum pharmacists that aim to highlight the "perks" of taking up permanent positions. The company said that the events would "dispel myths" over differences between locum and staff working.

RPSGB manifesto

The RPSGB has unveiled its manifesto ahead of the general election. The document demands the next UK government improve public health and early diagnosis by expanding nationally commissioned pharmacy services.

Payments hold firm

Payments for essential services this month will remain the same as for the previous six, the Department of Health (DH) has announced. Establishment payments and practice payments for April 2010 will remain at the same rates as those applied each month since October 2009, the DH confirmed in a statement.

AAH queries generic plan

AAH has added its voice to those demanding clarification from the government over proposals for generic substitution. Managing director Mark James said: "AAH has made a submission to the Department [of Health] to highlight two areas where further clarification is necessary."

Read the above stories in full at **chemistanddruggist.co.uk/news**

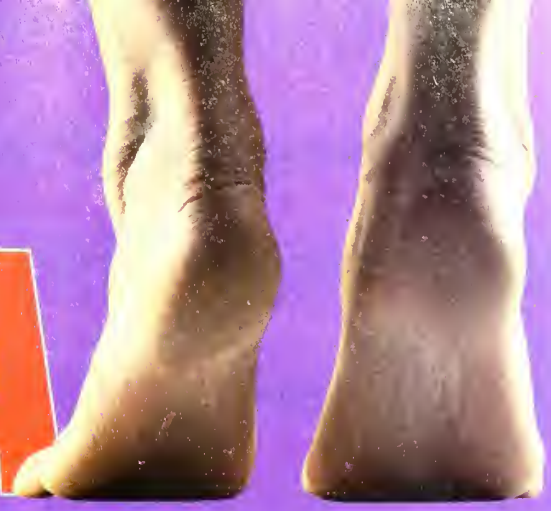
Aspirin effective option in migraine pain relief

A combination of aspirin and metoclopramide is as effective as OTC sumatriptan in treating migraines, a meta-analysis has found.

The Cochrane review found that 900-1,000mg of aspirin was just as effective in reducing pain from migraine as sumatriptan 50mg, reducing moderate to severe pain to either mild or no pain in half of patients within two hours. When combined with metoclopramide, the review found aspirin had a "similar effect to sumatriptan, tackling nausea and vomiting as well as photophobia and phonophobia".

Sheena Derry, senior research officer for the study, said: "We were surprised how effective they are... it's quite important to know how effective [OTC treatments] are."

The systematic review used data from 13 studies, with more than 4,000 participants. **CC**



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[1]IRI Infoscan, all outlets, Jan'10 unit sales

Dispensary talk

Could text reminders help patients take medicines properly?

"Not for all patients as most are very compliant. But it's a good idea for certain groups like those suffering mental illness. These people may be more likely to forget because of their condition."
John John, Day Lewis Pharmacy, Newent, Gloucestershire

"I run a warfarin clinic and compliance is an issue. For the forgetful patients it would really work. But are the people who aren't remembering really up to speed with technology like mobile phones?"
Lorraine Moore, Rowlands Pharmacy, Sunderland

Web verdict

Yes 70%

No 30%

Armchair view: People already use text reminders to better manage bank accounts and hair appointments. Prompts to stop you forgetting to take medicines will be [illegible], according to poll voters.

[illegible]'s question: Who would be your first choice as the next NPA chief executive? Vote at www.chemistanddruggist.co.uk

Quick thinking pre-reg rescues injured man

London pre-reg uses first aid skills to help worker who fell from lorry

Maeve Hosea

A pre-reg pharmacist stepped in to save a man badly injured after falling off a lorry near his West London pharmacy.

Sam Akhlaghi administered first aid after an accident on an industrial estate near Acton last month.

"One of the workers had fallen off a lorry, impacting his neck and was suffering internal bleeding," he told C+D. "I started doing normal things, holding him still and talking to him so that he didn't lose consciousness. My trousers were covered in blood because he was bleeding from his mouth and nose."

The man was rushed to hospital where his condition has now stabilised, Mr Akhlaghi added.

He said: "Thankfully, after going into a coma he made it and is now in recovery. It was really satisfying for me because I felt like I was worth something."

The pre-reg had recently completed a first aid course as part of his training at Jallas Pharmacy.

The incident highlighted the importance of equipping all new pharmacists with first aid skills, said Mr Akhlaghi's tutor Vibhaker Patel.

"Sam acted quickly, taking permission from the pharmacist on duty and running out to help. He had just attended a first aid course on the Propharmace pre-reg training programme."

Sam Akhlaghi was covered in blood after rushing out of the pharmacy to assist

Formal first aid training is not a legal requirement for pharmacists. But the Health and Safety Executive recommends pharmacy owners consider the public in their needs assessment, PSNC said.

Steve Lutener, PSNC head of regulation, said: "Pharmacies are often the first place where first aid is sought, and, as this commendable individual has exemplified, pharmacists and their staff can be ideally placed to step in and support."

Should first aid training be mandatory for all pharmacists?

max.gosney@ubm.com

Struck off for morphine error that was blamed on assistant

A Cambridge pharmacist who supplied a cancer patient with 10 times the prescribed dose of morphine has been struck off.

Achmat Rossier of Milton Road Pharmacy was "an unwarranted risk" to patients, a disciplinary panel heard last week.

Mr Rossier had shown "a degree of arrogance" over the error, which he blamed on a pharmacy assistant, the panel said.

A 71-year-old man died a few days after the incident in June 2006. No pharmacy staff were prosecuted as medical evidence could not prove the morphine supplied had caused the death.

But Mr Rossier's conduct rendered him unfit to practise as a pharmacist, the disciplinary hearing in London concluded.

Panel chair Siobhan Goodrich said: "Afterwards he received advice from a Society inspector but didn't act, displaying a degree of arrogance. He's learnt little from 2006, believing he was a man betrayed by his dispensing assistant."

Mr Rossier admitted supplying the patient with 100mg morphine sulphate tablets against a prescription calling for 10mg tablets.

Mr Rossier, a pharmacist for over 40 years, told the panel: "I have dispensed 2.5 million prescriptions and made only two errors. Improvements were made and I'm terribly sorry."

Simon Wiklund, for the RPSGB, said procedures that had been laid down were not complied with at the pharmacy.

Mr Rossier had given the tablets in a tray, which showed when they should be taken. The tray had been prepared by his assistant.

Concluding the hearing, Ms Goodrich said: "The events were very serious, involving multiple personal and systemic failures resulting in the death of a terminally ill man."

Mr Rossier has three months to appeal the decision. **UKL**

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Dulcoease Product Information Presentation: docusate sodium 100 mg capsules. **Indication:** Stool softener in the prevention and treatment of chronic constipation; to soften hard, dry stools to ease bowel movement and reduce straining or to prevent hard, dry stools and reduce straining in the presence of haemorrhoids (piles) or anal fissure. **Dose:** *Adults, Elderly and Children 12 years and over:* One capsule up to 5 times per day (maximum 500 mg). Initially try 3 capsules and adjust according to need. Reduce the dose when you feel more comfortable, usually 1-2 days. *Children under 12 years:* Not recommended. **Contraindications:** Do not take if you have abdominal pain, nausea, vomiting, intestinal obstruction, hypersensitivity to any constituent, or fructose intolerance. Do not take with a mineral oil laxative. **Precautions:** Consult a doctor if you have persistent stomach ache, or need this medicine every day. *Contains sorbitol.* do not take if sorbitol or fructose intolerant. Contains colouring E110. Please see doctor before taking if pregnant, thinking of becoming pregnant, or breast feeding. **Side-effects:** Rarely diarrhoea, nausea, abdominal cramps or skin rash. **Distributor:** Boehringer Ingelheim Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire, RG12 8YS, UK. **Product Licence Holder:** UCB Pharma Limited, 208 Bath Road, Slough, Berkshire, SL1 3WE, UK. **Presentations and recommended retail price:** 30 capsules £4.88. PL 00039/0737 (GSL). For full product information please see summary of product characteristics. Updated December 2008. **Dulcobalance® Product Information Presentation:** Presentation: Dulcobalance containing 10g of macrogol 4000 in a sachet. **Indication:** Symptomatic treatment of constipation in adults and children aged 8 years and above. **Dosage:** 1 to 2 sachets dissolved in water per day, preferably taken as a single dose in the morning. In children treatment should not exceed 3 months. **Contraindications:** Severe inflammatory bowel disease (e.g. ulcerative colitis, Crohn's disease), or toxic megacolon associated with symptomatic stenosis, digestive perforation or risk of digestive perforation, ileus or suspicion of intestinal obstruction, painful abdominal syndromes of indeterminate cause, hypersensitivity to macrogol or any of the excipients. **Warnings and precautions:** Patients with hereditary problems of fructose intolerance should not take Dulcobalance. In case of diarrhoea, caution should be exercised in patients who are prone to a disturbance of water electrolyte balance (e.g. the elderly, patients with impaired hepatic or renal function or patients taking diuretics). **Pregnancy and lactation:** No data is available in pregnant women, therefore caution should be exercised when taking Dulcobalance during pregnancy. As macrogol is not significantly absorbed, Dulcobalance may be taken during lactation. **Adverse effects:** *Common* abdominal distension and pain, nausea, diarrhoea. *Uncommon* vomiting, urgency to defaecate, faecal incontinence and bloating. *Very rare:* Hypersensitivity reactions including pruritus, urticaria, rash, face oedema, Quincke oedema and isolated case of anaphylactic shock. *Unknown:* Diarrhoea leading to electrolyte disorders (hyponatraemia, hypokalaemia) and dehydration. **RRP (ex VAT):** £4.25, 10 sachets. **Legal category:** P. **Product Licence Number:** PL 00015/0318. **Product Licence Holder:** Boehringer Ingelheim Ltd., Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. **Date of revision:** April 2010. **Dulcolax Tablets Product Information Presentation:** bisacodyl 5mg tablets. **Indication:** Short term relief of constipation. **Dose:** *Adults and children over 10 years:* One to two tablets at night. *Children under 10 years:* should only take Dulcolax tablets without medical advice. *Children 4-10 years:* One tablet at night. *Children under 4 years:* not recommended. **Contraindications:** Intestinal obstruction, ileus, acute abdominal conditions including appendicitis, acute inflammatory bowel diseases, severe abdominal pain associated with nausea and vomiting, severe dehydration, and hypersensitivity to bisacodyl or any other ingredient. **Precautions:** Not to be taken on a continuous daily basis for more than five days without investigating the cause of constipation. Prolonged excessive use may lead to electrolyte imbalance and hypokalaemia. Electrolyte imbalance may lead to increased sensitivity to cardiac glycosides. Contains a small amount of lactose and sucrose - patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine. **Pregnancy & lactation:** Not to be taken in pregnancy, especially the first trimester, and during breast feeding, unless the expected benefit is thought to outweigh any possible risk to the foetus. **Side-effects:** *Uncommon* vomiting. *Common* abdominal discomfort, abdominal pain, abdominal cramps, nausea and diarrhoea. *Not known* hypersensitivity including anaphylactic reactions and angioneurotic oedema and colitis. **Product Licence Holder:** Boehringer Ingelheim Ltd, Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire, RG12 8YS. **Pack size and recommended retail price:** 10 tablets £1.22, 20 tablets £2.05, 40 tablets £3.81. PL 00015/0240. **Legal category:** GSL. 60 tablets £4.59, 100 tablets £5.57. PL 00015/0241. **Legal category:** P. For full product information please see summary of product characteristics. Prepared in March 2009.

The road ahead for the NPA

As the National Pharmacy Association loses its second chief executive in just over two years, **Zoe Smeaton** asks what the future holds for one of the sector's best known bodies

Despite losing John Turk and Alison White in relatively quick succession, NPA chairman Ian Facer says the future path is clear

The loss of a second chief executive in just over two years is "not ideal", admits the NPA board's chairman, Ian Facer. But John Turk's surprise departure last week doesn't spell the end, or even a pause, for the association, he claims.

Mr Facer says the restructuring programme the association has been going through over the past 18 months is approaching completion, although he admits the changes have not been delivered entirely within planned timescales. Indeed, the association is still consulting on making a further four people redundant within its communications directorate.

But Mr Facer says the NPA is in a strong position. Staff have been retrained, new employees recruited and improvements such as IT systems installed to enable contractors to better manage their businesses, he says. Chief executive or not, it's very much business as usual, the NPA chairman says.

But just what does 'business as usual' need to look like if the association is to punch its weight over the next few years?

Mr Facer says the NPA's previous strategies have "largely" been met, although he doesn't offer specific examples. But he says the association has been developing its plans to reflect the evolving needs of contractors. "We have a very clear remit, which is to provide services that support pharmacists," he says.

And moving forwards, the association is to stick to three clear roles – representing, supporting and protecting members – using new independent research into what members want to inform its moves.

John D'Arcy, who was chief executive at the NPA for over a decade, says the association should seek to become guide and interpreter for contractors: "They should say, 'This is what you need to do, and this is how you can do it,' he said.

Mike Hewitson of Beaminster Pharmacy in Dorset has just been elected to the NPA board and says he wants the association to defend contractors against the increasing regulatory burdens being placed on them. He is also clear that it must also stand up for owners against the sector's regulator on matters where the commercial and professional interests of pharmacists come into conflict. "There's a line to be drawn between what is best professionally and what is actually practical – the NPA has a role in defining where that line is drawn," he explains.

> **"It might not be 'ideal', but John Turk's departure doesn't spell the end for the NPA, says chairman Ian Facer"**

Another widely discussed option for the association is to look outwards and possibly merge with another pharmacy body. Salim Jetha, chief executive at Avicenna, says such a merger could help to give the sector one voice, as well as bringing costs down for those involved through economies of scale. He says the departure of Mr Turk should be seen as "an opportunity for the current boards of the NPA, PSNC and the professional leadership body (PLB) to put their differences aside and explore opportunities of working together for the betterment of pharmacy". He adds: "If that means changes in constitution, so be it – let members vote on it." And George Romanes, of the Romanes Pharmacy group, agrees a merged organisation could have more clout and gravitas, bringing political benefits for the sector.

Others disagree on the case for collaboration, however.

Mr Hewitson is quick to rule out a merger with the PLB, saying: "The PLB has got to be very professionally focused and that's all well and good but someone has got to look after the commercial viability of pharmacy too and that's where the NPA lies."

Perhaps more interesting is the possibility of a merger between the NPA and the CCA, which C+D understands has at least been considered by some and could make sense given that CCA members now represents the majority of the NPA's membership too.

Rob Darracott, chief executive at the CCA, says: "It's correct to say that the CCA and the NPA have had initial discussions about the principles by which closer community pharmacy representation needs to be achieved." But he adds that there are "no specific proposals at the moment".

Mr Facer doesn't rule the idea out either, and says as the NPA "beefs up" its representative role: "If there is a better way of doing that then we will look at it."

However, this merger could also have problems as it might marginalise the NPA's independent members, leaving them wanting their own voice. Instead, Mr D'Arcy suggests adopting a federation model, with one umbrella organisation speaking for pharmacy as a whole, but all the other bodies sitting beneath it representing their various groups. Mr Hewitson agrees this could be a way forward. "All these organisations do have some overlapping functions and requirements and there may be no need to have 100 people in an office, another 100 there and others elsewhere." Mr Facer says he too thinks the model is a "useful" idea and one that he is prepared to raise in future meetings.

Whatever model the association chooses to adopt though, even if it opts to stay as it is, it's clear that there is pressure from many of its members for it to use the departure of Mr Turk as an opportunity to stride forwards and improve links with other pharmacy bodies.

Achieving the long-coveted unified voice will not be easy, but over the coming year all eyes are likely to be on the new NPA chief executive to see if they can help deliver it, and stay the course.

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Essential Information Nurofen Plus Tablets contains 200mg ibuprofen and 12.8mg Codeine phosphate **Indications:** For the short term treatment of acute, moderate pain (such as rheumatic and muscular pain, backache, migraine, headache, neuralgia, period pain and dental pain) when other painkillers have not worked. **Dosage and Administration:** For oral administration and short-term use only. Adults: 1 or 2 tablets every 4 to 6 hours. At least four hours between doses. No more than 6 capsules in any 24 hour period. Not to be taken for more than 3 days continuously. The patient must consult a doctor if symptoms persist or worsen, or if the product is required for more than 3 days. Not to be taken less than 4 hours after taking other painkillers. The Elderly: No special dosage modifications are required for elderly patients, unless renal or hepatic function is impaired, in which case dosage should be assessed individually. Not for use by children under 12 years of age. **Contraindications:** Hypersensitivity to ibuprofen or other constituent. History of hypersensitivity reactions (e.g. asthma, rhinitis, angioedema, or urticaria) in response to aspirin or other non-steroidal anti-inflammatory drugs. History of, or existing gastrointestinal ulceration/perforation or bleeding. Severe hepatic failure, severe renal failure or severe heart failure. In last trimester of pregnancy there is risk of premature closure of the foetal ductus arteriosus. Onset of labour may be delayed and the duration increased with increased bleeding tendency in both mother and child. Hypersensitivity to codeine, respiratory depression, chronic constipation. **Precautions and Warnings:** Caution in patients with certain conditions, which may be made worse, e.g. systemic lupus erythematosus and mixed connective tissue disease, gastrointestinal disorders and chronic inflammatory intestinal disease, hypertension and/or cardiac impairment, renal impairment, hepatic dysfunction. The elderly are at increased risk of the consequence of adverse reactions. Bronchospasm may be precipitated in patients with bronchial asthma or allergic disease. Do not use with other NSAIDs, including COX-2 specific inhibitors. Female fertility may be impaired by a reversible effect on ovulation. GI bleeding, ulceration or perforation. Caution is required in patients on medications which increase the risk of gastrotoxicity or bleeding. If GI bleeding or ulceration occurs, stop treatment and refer to a doctor. If mucosal lesion, skin rash or other sign of hypersensitivity occurs, the treatment must be stopped. This medicine contains codeine which can cause addiction if you take it continuously for more than 3 days. If you take this medicine for headaches for more than 3 days it can make them worse. **Side Effects:** Hypersensitivity reactions may include non-specific allergic reactions, anaphylaxis, respiratory tract reactivity (e.g. asthma, bronchospasm) and various skin reactions (e.g. pruritus, urticaria, angioedema). Side effects to codeine include constipation, respiratory depression, cough suppression, nausea and drowsiness. Regular prolonged use of codeine is known to lead to addiction and symptoms of restlessness and irritability may result when treatment is then stopped. **MRRP** (excl VAT): £2.36 (12 tablets) £4.44 (24 tablets) £5.28 (32 tablets) **Legal Category:** P **Product Licence Numbers:** PL 00032/0082 **Licence Holder:** Crookes Healthcare Limited, Nottingham NG2 3AA. **Date of Preparation:** March 2010 **References** 1 McQuay et al. Anaesthesia 1992;47 672-677

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk
Adverse events should be reported to Reckitt Benckiser on 0500 455 456

E-cloth offers clean sweep

EnviroProducts is launching its allergy and asthma friendly e-cloth range into UK pharmacies.

The chemical-free cleaning brand is designed to help ease allergies and asthma and carries Allergy UK's consumer award to highlight its credentials to allergy sufferers.

The range includes three cleaning cloths – General Purpose Cloth, Glass & Polishing Cloth, and Antibacterial Cloth– guaranteed for 300 washes.

A marketing campaign includes instore support to help pharmacists communicate how the products can help allergy sufferers.

Price: single cloths £4.99
EnviroProducts
Tel: 01892 893131

Almus widens generics range

Almus Pharmaceuticals has extended its range of generic medicines with five POM lines.

New in the range are hydrocortisone 10mg and 20mg (30 tablets), dexamethasone 2mg (50 and 100 tablets) and clonidine hydrochloride 25mcg (112 tablets).

The colour-coded packaging has been designed for clear product differentiation to help provide accuracy in dispensing and safety for both the pharmacist and patients.

"The products are designed to ensure that the range has the appropriate balance of important niche lines as well as the top generics required in the dispensary," says Almus Pharmaceuticals.

Almus Pharmaceuticals
Tel: 0800 032 0579

Fresh look reinforces Biotène's protective role

GlaxoSmithKline Consumer Healthcare is introducing a new look for three Biotène products.

Oralbalance Saliva Replacement Gel, Fluoride Toothpaste and Moisturising Mouthwash have been repackaged with a more prominent logo and greater emphasis on the brand's role in the protection against dry mouth.

The gel and mouthwash, which are medical devices, both feature the claim "for relief of dry mouth". The toothpaste now states that it "supplements saliva's natural defences and strengthens teeth".

The mouthwash is now in a 500ml size, replacing the 250ml bottle.

Price: toothpaste £6.50/75ml, gel £7.49/50g, mouthwash £9.99/500ml
Pip codes: See C+D Monthly Pricelist or www.cddata.co.uk
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
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To sell or not to sell, that is the OTC question

> WHAT OTHER BUSINESS SPENDS HALF ITS TIME DECLINING SALES?

"No, I'm not prepared to sell you four packets of laxatives. Yes, I know you could just go elsewhere. Yes, I know we sold you two packets last week, but now I will only sell you one. No, I'm sorry; if two are for your friend, then your friend must come in..."

Repetition of this morning's conversation probably sounds familiar. That wonderful OTC 'grey area' of proportionate sales restriction, usually followed by the patient's favoured riposte of "I never have this trouble at the other pharmacy!". So to sell or not – even the most simple of products such as 32 paracetamol can become a battle.

If only OTC sales were as clear cut as dispensing, where a GP has selected the appropriate treatment and all we have to do is supply without error. And now, at last, it seems the Prosecution Service will soon recognise we are human and single errors will not automatically result in a criminal conviction.

Ah, sweet, innocent reader – of course it's not that simple! This is now an age of 'pharmaceutical assessment', which extends to more than checking the dose in the BNF, for we must also satisfy ourselves that the prescribing is safe and proper. For example, ensuring patients have had blood tests before dispensing warfarin or lithium, along with the ubiquitous guiding phrase "use professional judgement as to whether it is appropriate to dispense". So, if the script is being collected by a carer who hasn't a clue, and the patient can't be contacted, is it appropriate to dispense? If the patient hasn't had a recent test, but has run out of lithium, is it appropriate to decline? And who can deny that judgement of what is appropriate varies according to time, busy pharmacy, and how much steam is emitting from the patient's ears.

And despite the brave new world of the 'Primary Healthcare Team', it can still be intimidating to question some prescribing decisions without seeming picky or jobsworth. What is too much – 500 erythromycin tablets? Two years' supply of contraceptive? Three hundred codeine tablets a week? Each time the prescribers argued with me that it was an appropriate amount – with varying success – though I hope even I would think twice about the supply of six month's methadone tablets to one lucky winner, reported in last week's C+D.

Hard as it is in a busy pharmacy, we do have to stop and think through the grey area, and the best thing we ever did was to get "Disp'd" and "Check'd" boxes added to our labels, because they force me to take a 'mental break' before initialling.

What other business spends half its time declining sales? But then part of the arguments against remote supervision, and the slippery slope of POM to GSL moves, is that we are unlike any other business. Even so, no surprise if the next 'grey area' is the hair on my head!

Making sense of the Drug Tariff

The Drug Tariff crosses my path at frequent intervals. I think the public would be amazed that the remuneration of some healthcare professionals is governed by the minutiae in a monthly paperback.

The Drug Tariff is so arcane that I have had cases in the past when pharmacists have been prosecuted for fraud because they failed to understand the fine print. For example, one pharmacist received a prescription for "ordinary" syringes. He dispensed standard plastic syringes, which is what the prescriber intended. He didn't realise that the Drug Tariff lists an "ordinary purpose syringe", which is made of glass and much more expensive than plastic syringes. Needless to say, the jury didn't take long to return a verdict of 'not guilty'.

The complexities of the Drug Tariff are worse when it comes to [illegible] there is a PPD investigation underway to see that the NHS spends a lot of money footing the bill for specials, but the answer would be to regulate payments through some clear words in the Drug Tariff. Perhaps I'm doing myself out of work by saying this, but pharmacy owners should be able to know what payments they can and cannot claim from the NHS without having to consult a lawyer.

There is a risk the NHS will lose sight of the fundamental principle that community pharmacy owners are entitled to be paid fair and reasonable remuneration in a timely fashion. This should be self-evident, but in Northern Ireland (NI), where I act for the Pharmaceutical Contractors' Committee, it was necessary to go to court to get a ruling to this effect from the Lord Chief Justice. The judge declared that the Northern Ireland Drug Tariff – including category M – is unlawful. The ruling doesn't apply to category M in England, Wales and Scotland. The difference in NI was the absence of any advance consideration of the impact category M would have. A senior health department official in NI had even admitted in a letter that category M was not fit for purpose.

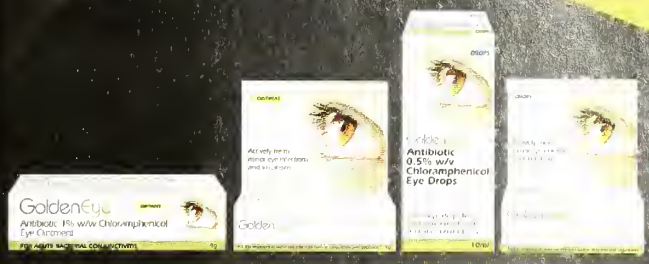
I see this use of the Drug Tariff, investigating specials, and the use of branded generics as part of the same jigsaw, attempting to limit what pharmacists are paid. Of course, the more remuneration is restricted, the more pharmacy owners will look for other revenue streams like exporting. The latest DH announcement that tougher action will be taken just demonstrates what I have been saying all along: that the DH accepts exporting is lawful, and it is not unprofessional as long as exporters go about it in the right way.

If the Drug Tariff was clearer and focused more on ensuring pharmacy owners receive fair and reasonable remuneration in a timely fashion, everyone would be better off.

David Reissner is a partner at Charles Russell LLP, where he is head of healthcare

> PHARMACY OWNERS SHOULD BE ABLE TO KNOW WHAT PAYMENTS THEY CAN CLAIM WITHOUT HAVING TO CONSULT A LAWYER

Brandfocus



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Age restrictions: Golden Eye Antibiotic Drops and Ointment – Chloramphenicol drops and ointment are not suitable for use in children under the age of two years. All other age groups can use these products.

Golden Eye Drops and Ointment – There is no lower age limit for the use of these products. However, conjunctivitis in children under 3 can be virulent and therefore the child may need alternative treatment.

Golden Eye Antibiotic 1% w/w Chloramphenicol Eye Ointment Marketing Authorisation held by: Martindale Pharmaceuticals Ltd., Bampton Road, Romford, RM3 8UG. **Golden Eye Antibiotic 0.5% w/v Chloramphenicol Eye Drops** Marketing Authorisation held by: Tubilux Pharma SpA, Via Costanza 29/23 00040 Pomezia, Rome, Italy. Distributed by: Typharm Ltd, 14D Wendover Road, Rackheath Industrial Estate, Norwich, NR13 6LH. Indications: For the topical treatment of acute bacterial conjunctivitis. **Golden Eye 0.1% w/v Eye Drops Solution and Golden Eye 0.15% w/w Eye Ointment** Marketing Authorisation held by: Typharm Ltd, 14D Wendover Road, Rackheath Industrial Estate, Norwich, NR13 6LH. Indications: For the treatment of minor eye or eyelid infections, such as conjunctivitis and blepharitis. Legal Category: P. Further prescribing information is available from Typharm Ltd. at the address above.

It is not easy for a man to come to the counter and admit that he is having a problem with his waterworks. Men over the age of 40 are not typical pharmacy customers and may be reluctant to discuss the potentially embarrassing lower urinary tract symptoms (LUTS) caused by benign prostatic hyperplasia (BPH).

Now Flomax Relief is available over the counter to treat the functional symptoms of BPH,[1] pharmacists and staff need to ensure such enquiries are handled sensitively and discreetly, and use a private area for consultations.

Make medicines counter staff aware of Flomax Relief and what it is for, since they are likely to be the first point of customer contact (a training guide is available).

Points to consider:
Why has the patient come to see you? Men tend to put up with the symptoms associated with BPH, so if they have come to you for advice it's important you take them seriously.

Assess the severity of LUTS, but be aware that men vary considerably in their tolerance — some with mild symptoms are severely bothered by them, and others with more severe symptoms simply want reassurance nothing serious is wrong.

Explore factors that may aggravate urinary symptoms:[2]
- Diuretics, or drugs with antimuscarinic or sedating adverse effects (e.g. cold and flu remedies, sedating antihistamines, tricyclic antidepressants)
- Alcohol and caffeine consumption

FLOMAX relief® MR

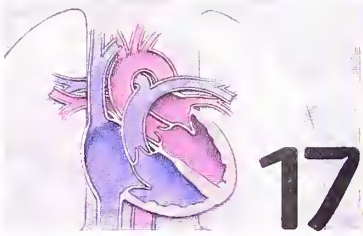
References

Flomax Relief® MR. Presentation: Contains 0.4mg of tamsulosin hydrochloride in a modified release capsule. Indication: Treatment of functional symptoms of benign prostatic hyperplasia (BPH). Dosage: For men aged 45-75 years. For oral use. One capsule daily. Legal Category: P. PL Number: PL 00015/0280. Further information available from: Boehringer Ingelheim Limited, Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire RG12 8YS.

Features

Election countdown 2010

C+D's election coverage kicks off with a look back at the policies and legislation that have affected pharmacy over the last 20 years and an exclusive interview with Tory pharmacy minister Mark Simmonds



Update: CHF

The symptoms, diagnosis and latest treatment explained

Practical Approach

Does it have to be the Pill for painful periods, asks a worried mum?

Focus on allergies

Antihistamine sales are rising, so make sure your pharmacy's ready

Postscript

Sharpen your pencils for our Avicenna caption competition

Update

Your weekly CPD revision guide

Chronic heart failure

A guide to the symptoms, diagnosis and latest treatment of CHF

Russell Greene MRPharmS

60-second summary

New understanding of chronic heart failure (CHF) has led to significant changes in the approach to treatment. This article, which can be used as part of your CPD, explains recent findings.

What is the first line treatment and why?

Instead of forcing the damaged heart to work harder, the aim now is to decrease the load on the heart. ACE inhibitors do this by making it easier for the ventricles to pump, and by reducing renal fluid retention. The next step is to add a beta-blocker (carvedilol, bisoprolol or nebivolol) to protect the heart from excessive adrenergic stimulation. Diuretics are used only if there is oedema.

Is digoxin no longer used?

Digoxin is now only used if ACE inhibitors have failed to control atrial fibrillation.

This article (Module 15.2) can be used for the following CPD competencies: C1a, C1b, C1c, C2a. See http://tinyurl.com/6cor7b

Chronic heart failure (CHF) is a common, potentially fatal illness that follows the inability of the heart to supply the body's demand for blood circulation, especially its failure to respond to exertion. It is a syndrome with many different possible causes but a uniform range of signs and symptoms.

Moreover, it is a multisystem condition, because poor circulation affects other crucial body functions, especially the muscles, lungs and kidneys.

CHF is predominantly a condition of the middle aged and elderly, with a prevalence of about 4 per cent in those over 70 years. Males and females are equally affected. It usually results either from direct damage to the heart, eg from ischaemic heart disease (IHD, the commonest cause), arrhythmia, valve disease or myopathy (a disease of cardiac muscle), or it follows chronic overloading, usually the result of untreated hypertension.

In developing countries, infections are a common cause, as used to be the case in the West when heart valve disease secondary to rheumatic fever was more prevalent before the advent of antibiotics. Smoking and diabetes are risk factors.

CHF should be distinguished from cardiac arrest, angina or myocardial infarction, although it often follows MI. The conditions are often confused because patients with CHF frequently have other cardiovascular co-morbidities, and these are usually causally related. Thus hypertension is a potential cause of both IHD and CHF, and IHD itself can cause CHF and arrhythmias (but not hypertension).

As a result many cardiac patients present at pharmacies with multiple diagnoses and a variety of cardiovascular prescriptions. It may then be difficult to unravel cause and effect, especially as several cardiac drugs (eg beta-blockers, ACE inhibitors) have multiple indications.

Understanding of the pathology of CHF has changed. Damage to heart muscle is the primary factor, but it has become clear that many of the worst problems result not directly from this but from the body's attempts to compensate for the failing heart. These include cardiac enlargement, renal fluid retention, vasoconstriction, and excessive activity of the sympathetic (adrenergic) nervous and the renin-angiotensin-aldosterone (RAA) systems. These feedback mechanisms attempt to restore blood pressure and cardiac output, but instead result in a vicious cycle of further cardiac overloading and damage.

Signs and symptoms

CHF usually progresses slowly. At first it may merely seem to the patient like signs of ageing. The classic triad of symptoms are:

- shortness of breath (SOB), initially only on exertion (due to pulmonary congestion)
- fatigue (due to poor muscle perfusion)
- oedema, usually around the ankles initially.

Each alone could have a variety of other causes, and most are serious. A few routine questions about onset, progression, timing, other diseases (especially cardiac) and medication would be appropriate. However, patients must be referred to their GP, particularly if complaining of the combination of SOB, fatigue and swelling. CHF cannot be managed or even ameliorated by primary pharmaceutical intervention.

Clinical features of heart failure

Congestion

- Pulmonary oedema: cough, wheeze, dyspnoea, PND, cyanosis
- Peripheral: ankles, calves
- Abdominal: pain, ascites, nausea, anorexia

Poor perfusion

- Cyanosis, pallor
- Cold extremities
- Fatigue, exercise intolerance
- Tachycardia
- Renal fluid retention

Other symptoms include cyanosis (bluish tinge), cold extremities, palpitations, cough or wheeze and anorexia (see panel above). A disturbed sleep pattern is characteristic: patients describe waking breathless after a few hours and feeling the need to 'get up for a breath of fresh air'. After return to bed, the sequence is repeated. This is paroxysmal nocturnal dyspnoea (PND), a classic sign of pulmonary congestion secondary to CHF, caused by pulmonary oedema fluid spreading throughout the lungs when recumbent. Getting up allows the fluid to settle at the lung bases and free upper parts for gas exchange. Such patients are usually advised to sleep propped on several pillows.

Investigations and diagnosis

The GP will listen to the chest for signs of possible causes (eg arrhythmia, valve disease) or consequences (lung congestion). The severity and extent of peripheral oedema will be judged. Typically, gently depressing an oedematous area

and releasing the pressure will leave a pit that only refills slowly (pitting oedema). Swelling of the jugular vein in the neck (jugular venous pressure – JVP) will indicate the severity of pumping abnormality.

Investigations are then needed to measure severity. The commonest is echocardiography, which uses ultrasound to visualise the beating heart and can quantify the extent of ventricular failure by measuring the ejection fraction (EF), ie how completely the heart empties with each beat. Normally this is better than 60 per cent.

More recently a raised level of the biochemical marker natriuretic hormone (brain natriuretic peptide – BNP) is used to indicate severity and follow recovery. Potentially correctible causes or aggravating factors must also be sought. This requires tests for urea and electrolytes, renal, liver and thyroid function, blood count and ECG.

Other tests may be required to identify possible causes or exacerbating factors, which may indicate specific treatment (eg arrhythmia, anaemia, ischaemia and hypertension). An ECG may show signs of 'cardiac strain', which usually suggests untreated hypertension. A medication history is essential because drugs may cause or exacerbate CHF (eg beta-blockers, NSAIDs, some calcium channel blockers and steroids).

However, heart failure is graded not on these measures but on a pragmatic scale known as the New York Heart Association (NYHA) classification, shown below with the approximate echocardiography range:

- **Class I** Asymptomatic. No symptoms at ordinary physical activity (EF 50-60 per cent).
- **Class II** Mild. Breathlessness and fatigue evident on strenuous exertion (EF 40-50 per cent).
- **Class III** Moderate. Breathlessness and fatigue evident on moderate exertion (EF 30-40 per cent).
- **Class IV** Severe. Breathlessness at rest (EF less than 30 per cent).

CHF is not commonly thought of as fatal but the more severe grades have a poorer prognosis than many forms of cancer. For Class IV, only half of sufferers can expect to survive one year, while for Classes II and III the figure is three to five years. The annual mortality rate from asymptomatic left ventricular disease (Class I) is about 5 per cent.

Treatment options

Traditionally the aim was to reduce symptoms with diuretics and cardiac glycoside stimulants like digoxin. However, this strategy had no effect on prognosis or survival. With the realisation that the failing heart was already under maximal [illegible] from the feedback mechanisms [illegible] the rationale changed from [illegible] of vainly forcing the already [illegible] heart to work even harder, the aim became to help the heart by unloading it and blocking the [illegible] stimuli. Eventually this brought about the seemingly counterintuitive use of beta-blockers, long believed to be dangerously contraindicated in heart failure. The overall success of this strategy has been demonstrated by the clear survival advantage it [illegible]. Other changes have included greater [illegible] multidisciplinary teams, and the use [illegible] in end stage disease.

[illegible] drugs remain the mainstay. The currently recommended sequence is shown in Figure 1 (online at www.chemistanddruggist.co.uk/update). Diuretics (usually loop) are still used, but only if there are congestive symptoms, especially pulmonary oedema. However, ACE inhibitors are the first line agents. By decreasing the vasoconstrictor action of angiotensin they relieve the afterload on the heart, making it easier for the ventricle to pump. They also inhibit the release of aldosterone, which reduces renal fluid retention: this lowers the venous return to the heart, further unloading it. In resistant failure this effect can be augmented with spironolactone (for its aldosterone blocking rather than its potassium-sparing diuretic effect). ACE inhibitors should be started on a low dose, watching for a first dose hypotensive effect, especially if the patient is already on a diuretic, and then titrated upwards till symptoms are controlled.

Beta-blockers are added for the next stage. They act by protecting the heart from excessive adrenergic stimulation. Their cardiac depressant action is still problematic so they should be carefully introduced by a specialist, starting at a low dose, and initially there may be a temporary moderate deterioration before improvement is seen. At present only carvedilol, bisoprolol or nebivolol are recommended. Again, careful up-titration is important.

Only if this combination fails will digoxin be added as the next step, with the usual precautions. The one exception is if the patient also has atrial fibrillation, when digoxin will be given first line owing to its anti-arrhythmic properties. While the other drugs have been shown to improve survival, this has not been clearly demonstrated for digoxin.

In the rare cases where this powerful combination still proves ineffective a number of other drugs may be tried (see Figure 1 online), but this would require a coronary care unit. The ultimate step, transplantation, remains uncommon.

Precautions and interactions

Particular care needs to be taken over potassium levels. Most diuretics lower these but ACE inhibitors tend to raise them, so potassium supplements or potassium-sparing diuretics are contra-indicated. Indeed, the combination of ACE inhibitor and spironolactone can cause hyperkalaemia, even if the patient is on a diuretic, so potassium levels must be monitored when drugs are added or doses changed. Conversely, the digoxin toxicity threshold is reduced in hypokalaemia. If a patient is already on a diuretic, this should be stopped 24 hours before initiating ACE inhibitors then cautiously reintroduced. Renal function should be checked before starting ACE inhibitors or digoxin and regularly thereafter. NSAIDs can seriously exacerbate nephrotoxicity of ACE inhibitors, as well as tending to worsen CHF because of their fluid-retention action.

For the few patients who cannot tolerate the cough associated with ACE inhibitors, angiotensin-2 receptor blockers (ARBs) are equally effective. With beta-blockers, there is a need to watch for signs of worsening failure with oedema, excessive bradycardia, or unusual fatigue or exercise intolerance. Care is needed in patients with diabetes or COPD.

Black people tend to respond poorly to ACE inhibitors, ARBs and beta-blockers when used for hypertension, but in CHF there are no alternatives so they must be used.

Pharmacists must be alert to digoxin toxicity. Dosage must be carefully individualised, particularly according to renal function, which is often reduced in CHF. Arrhythmias can ensue, and potassium levels must be monitored. Early toxicity signs include nausea, diarrhoea and blurred vision.

Lifestyle advice

Non-drug treatments include weight loss, fluid and salt restriction and moderation of alcohol intake. General cardiovascular risk factors must also be addressed, mainly smoking and diet (including cholesterol control). Patients are also advised to undertake regular gentle exercise consistent with their ability, although this is best initiated by the GP or a physiotherapist.

Figure 1 illustrating drug treatment of heart failure is online at www.chemistanddruggist.co.uk/update

Russell Greene MRPharmS is a pharmaceutical writer and consultant, and former senior lecturer in clinical pharmacy, King's College, London.

Further information

- www.patient.co.uk/health/Heart-Failure.htm
- www.cks.nhs.uk/patient_information_leaflet/heart_failure

Further reading

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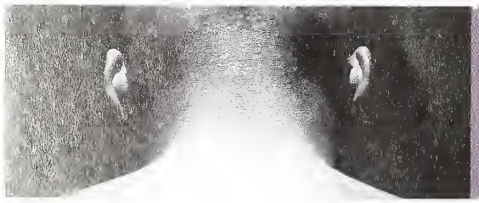
Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p20).



NEXT WEEK
The management of schizophrenia

Kills head lice with a 10 minute treatment time

- No Pesticides
- CLINICALLY PROVEN[1]
- Suitable for asthmatics
- No nasty smells
- No leaving it on overnight
- Works by stripping the louse of the outer coat, causing dehydration, shrinkage and death

Full Marks NOW on Scotland's minor ailment scheme[2]

Full Marks solution

SSL Full Mark[illegible] a Trade Mark of the SSL Group

For everything you need to know about head lice visit **headlice.co.uk**

The **NEW** simplified Full Marks Range comprises of Solution and Combs.

1 Burgess TF, Brown CM, Lee PN, Pharm Jnl 2008, [illegible], 371-375

2 To order Full Marks Solution, contact your local sales representative on 0870 122 2689

Chronic heart failure

Why might a patient with chronic heart failure experience sleep problems? What does a raised level of brain natriuretic peptide indicate? How do ACE inhibitors work in CHF? What are the symptoms of digoxin toxicity?

This article explains recent thinking behind the treatment of CHF. It includes information about the symptoms and diagnosis, and discusses the use of ACE inhibitors, diuretics, beta-blockers and digoxin.

- Read more about the management of heart failure on the Patient UK website at http://tinyurl.com/heart48.
- The Patient UK website also has some useful information about brain natriuretic peptide levels at http://tinyurl.com/bnp-levels.
- Revise your knowledge of the drugs used to treat heart failure from section 2.5 in the BNF.
- Consider the questions you might ask when carrying out an MUR with a CHF patient and read the C+D MUR tips for heart failure at http://tinyurl.com/MUR-heart. The Heart Failure Matters website may be a useful resource for your patients at http://tinyurl.com/ybmklsq.

Are you now familiar with the causes and symptoms of CHF? Are you confident in your knowledge of how it is treated? Could you give advice to patients or carers about this condition?

Practical Approach

Treating period pains

Lydia Allen, relief pharmacist at the Update Pharmacy, answers a call at her front door. It is her neighbour, Fiona.

Fiona says: "Lydia, I've got a query about a prescription. I wonder if you can help with it?"

Lydia agrees and Fiona shows her a packet of Microgynon-20 tablets.

"What do you think of these?" Fiona asks.

Are they for you?" says Fiona.

"No, they're for Charlotte."

Charlotte is Fiona's 15-year-old daughter and Lydia doesn't know exactly what to say.

"It's OK," says Fiona, chuckling at Lydia's obvious embarrassment, "they're not for contraception. The doctor prescribed them for her periods. But I'm wondering whether they're right for her. And Charlotte doesn't like the idea at all."

Lydia asks for more detail and Fiona explains.

"For the last few months poor Charlotte has been having the most terrible cramps at the start of her periods. They only last for the first day or so, but they're so bad that they keep her off school. Also her periods tend to be irregular and she gets very moody for a couple of days before each one."

"Did you try anything before you went to the doctor?" Lydia asks.

"Just paracetamol, but that was really no help at all. I suppose we should have asked for your advice earlier. But now we've got these pills, do you think it's worth me persuading Charlotte to take them?"

Questions

1. Why has Charlotte had bad period pains only for the past few months? (She has been menstruating since she was 13).
2. Why are combined hormonal contraceptives prescribed for dysmenorrhoea?
3. Are they effective?
4. What OTC treatment(s) might have been helpful, and why?

Answers

1. Menstrual cycles are anovulatory and often painless for up to the first two years. Dysmenorrhoea and premenstrual syndrome (PMS), which Charlotte also appears to be suffering, often begin with the onset of ovulatory cycles.
2. They inhibit ovulation and the reasoning is that they will eliminate or at least reduce dysmenorrhoea and PMS.
3. A Cochrane review found that combined OCPs with medium dose oestrogen (over 35mcg) and first/second generation progestogens were more effective than placebo for pain relief, and there was a significant difference in favour of OCPs when compared to placebo for the outcome of absence from work or school. However, no conclusions could be drawn about the efficacy of commonly used modern lower dose combined oral contraceptives.[1] (Charlotte has been prescribed a lower dose OCP).
4. Dysmenorrhoea is thought to be due to release of prostaglandins and leukotrienes in the menstrual fluid, producing vasoconstriction in the uterine vessels. This in turn causes the uterine contractions giving rise to pain. NSAIDs are the most commonly used drugs for the treatment of dysmenorrhoea due to their inhibition of prostaglandin synthesis. Ibuprofen, diclofenac and naproxen are licensed for non-prescription treatment of dysmenorrhoea.

Reference

1. Proctor, ML, Roberts, H, Farquhar, CM; Combined oral contraceptive pill (OCP) as treatment for primary dysmenorrhoea. Cochrane Database Syst Rev. 2001; (4).

This article can help with these CPD competencies: G1a, G1c, G1d, G2o, C1a, C1f.
See http://tinyurl.com/68ox7b

CATEGORY FOCUS

Allergies

Brands, alternative formats and children should be the focus to boost your share of the £55m allergy market, finds **Sarah Thackray**

Last year the Met Office memorably suggested the UK could expect a "BBQ summer", with high pressure leading to periods of sunshine. Sadly, this was not to be. Yet despite the temperatures being on the low side, sales of antihistamine products were not.

According to market analysts Kantar Worldpanel, the total £55 million allergy market has grown by almost 9 per cent in the last year, although the pharmacy sector has only grown by 2 per cent.

Pharmacy sales of own label products have been successful, increasing by 21 per cent, but there has been a 3 per cent decline in pharmacy sales of branded allergy products in the last year.

Numark's category manager, Emma Charlesworth, believes this is because customers are "quite savvy" about the allergy category and specific drug types such as loratadine and cetirizine. "They appreciate that brands have the same ingredient as an own label alternative which, of course, tends to be more competitively priced." However, Numark advises: "There is no need to sell customers the cheapest generic brand available. All you are doing is taking money out of your till and it doesn't lead to loyalty."

And a new hayfever and allergy report by GSK points out: "Price is not necessarily a factor in hayfever and allergy where early relief is needed. If pharmacists recommend trusted branded products rather than own label, they can help maintain value and boost profits.

"While GSL shoppers do worry about price and try to stick to a budget, P shoppers care less about how much they spend on a product as long as they receive quality. They are generally much more loyal than GSL consumers and it is in the best interests of pharmacy to encourage P purchase."

Believe it or not, the summer of 2009 was actually better (slightly less cold and wet) than the summer of 2008. This is significant for the allergy market, which is dominated by hayfever products, as a good summer produces more pollen, which in turn leads hayfever sufferers to rush to the shops to buy their remedies.

It is worth noting that about 70 per cent of market buyers only purchase once in the year. But more shoppers buying hayfever remedies on more occasions, combined with a price per pack increase, has led to a 9 per cent year-on-year market growth rate.

When put into context with the total OTC market, this category is worth only 4 per cent of the total, but has contributed about 34 per cent towards market growth.

Grocery is driving a huge chunk of this, showing 12 per cent growth compared to 2 per cent from pharmacy. Tablets, the most frequently bought format, are driving the majority of this growth. Capsules, however, are showing the most growth.

Buy one get one free offers, particularly effective in the grocery sector, on tablets in this market (as we saw in 2008) also helped drive category growth. But aggressive promoting in the grocery sector had an adverse effect on pharmacy, which has lost a little bit of share to the rival sector.

A drop in packs bought per trip is holding growth to just 2 per cent in pharmacy. The only drivers of growth for the sector is coming from the heavy shoppers who are buying on more occasions, along with an 8p increase in average price per pack.

It is important, based on last year's experience of the season arriving later than normal, for pharmacists to keep an even sharper eye on the weather and pollen forecasts to ensure they are stocked and ready for their customers.

Total market value
£54,950,000 — 9%

Pharmacy market value
£25,903,000 — 2%

Total market	Pharmacy
1. Benadryl	**1.** Piriton
2. Piriton	**2.** Benadryl
3. Piriteze	**3.** Piriteze
4. Clarityn	**4.** Clarityn
5. Galpharm	**5.** Beconase

Source: Kantar Worldpanel value sales, 52 weeks to February 21, 2010. Data and analysis provided for C+D by Kantar Worldpanel (strategic insight director, Tim Nancholas)

KANTAR WORLDPANEL

Independent Omnibus research shows that 26 per cent of the UK population purchased an antihistamine product last year, compared to 19 per cent in 2005.

Some of this increase in demand can be attributed to a growth in the numbers of new sufferers coming into the market. Allergy UK has estimated that the number of children in the UK suffering from one or more allergies is as much as 40 per cent.

With almost half of all allergy sufferers being children, GSK believes that the children's allergy sector will become increasingly important and says pharmacists are in the best position to help and advise parents, and explain the benefits of allergy syrups for children.

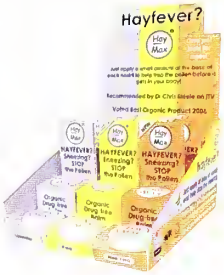
Education of the public is playing a role in the growth of the allergy relief market, according to Zirtek manufacturer UCB Pharma. "More

Product Watch

Otrivine and Otrivine Menthol

Manufacturer: Novartis Consumer Health
Classification: GSL
For: relief from nasal congestion as a result of colds, perennial and allergic rhinitis (including hayfever) and sinusitis
Active ingredients: Xylometazoline hydrochloride
How: Acts gently to clear blocked noses within minutes, with effects lasting for up to 10 hours
What's new?: Repackaged to feature clear communication of key benefits and colour coded designs to distinguish between variants
Contraindications: Sensitivity to ingredients. Trans-sphenoidal hypophy-sectomy or surgery exposing the dura mater.
Tel: 01403 218111

Haymax



Manufacturer: HayMax Ltd
Classification: GSL
For: organic drug-free pollen barrier balm for hayfever and allergies
What's new?: Shelf ready, filled and shrink-wrapped counter display unit with three of each variety plus three free tester pots. Product support will include TV, radio, magazine and newspaper advertising during the hayfever season
Contraindications: Allergy to beeswax.
www.haymax.biz
Tel: 0845 190 2283
Email: info@haymax.biz

Zirtek Allergy

Manufacturer: UCB Pharma
Classification: GSL
For: treatment of seasonal and perennial rhinitis and chronic idiopathic urticaria
Active ingredients: Cetirizine hydrochloride
What's new?: Multimedia campaign plus an updated website with a pollen forecast updated daily during the peak season. Zirtek will feature on high street posters in May/June, complemented by instore activity.
Contraindications: Hypersensitivity to cetirizine or any of the excipients.
www.zirtek.co.uk
Tel: 01202 780558
Email: info@zirtek.co.uk

accurate self diagnosis should in turn lead to increased demand for an effective treatment," comments Richard Bruggraber, head of commercial products at UCB.

"Higher levels of media coverage coupled with sustained promotional activity focusing on allergies in general, as opposed to just hayfever, has lead to an increase in understanding that allergies can occur all year round," UCB adds.

GSK points out that out of season sales are stronger in pharmacy and pharmacists are in a position to help and advise with conditions such as perennial allergic rhinitis.

Research shows that over 80 per cent of buyers only purchase tablets, with just 8 per cent buying more than one format. GSK says pharmacists can help drive sales of other formats such as syrups and sprays, which are currently underperforming.

"Sprays may suffer from a lack of understanding in terms of how they work and how they should be administered. According to shopper research, 14 per cent of sufferers would prefer a spray and 76 per cent would be willing to try one," says GSK.

Over recent years much of the major growth in this category has been driven by the grocery sector as many allergy relief products have switched from P to GSL, says Lynne Henshaw, Numark's director of trade marketing.

"Supermarkets offer heavy weighted promotions which can switch some customers away from pharmacy," she adds. "But community pharmacies are in an ideal position to provide the best advice and service to patients, so it's time to take action, realise your pharmacy's potential and keep this category firmly in pharmacy – where it belongs!"

Brand Watch: The Piri team

GlaxoSmithKline Consumer Healthcare has aligned its Piriton and Piriteze brands more closely under a single range. GSK says this will assist pharmacy staff in recommending appropriate products and ease customer recognition of individual products.

The introduction of the new Piri Team will enable the company to support the entire range while capitalising on the Piriton brand heritage.

Piriton is the leading allergy brand in pharmacies (Kantar Worldpanel value sales 52 weeks to February 21, 2010) and GSK says that the 60s pack, introduced in 2008, is delivering the greatest sales in pharmacy.

The Piri Team will be supported by a new £2.4 million TV advertising campaign from May to help increase awareness and drive sales. POS materials and category management initiatives are available from GSK.

Top tips for boosting sales of allergy products

1. "The biggest months are always May and June when the grass pollen is out, so make sure that you've got hayfever products displayed prominently – preferably on the counter."
Mark Wiseberg, managing director, MayMa

2. "Position the allergy category at eye level and signpost it with Piriton, the brand leader. Own label products should be positioned alongside their branded counterparts."
Emma Charlesworth, category manager, Numark

3. "Promote or feature allergy products all the year round to maximise allergy sales as there are many customers that suffer from allergies outside of the traditional hayfever season."
Brand manager, Otrivine

4. "Treat every person as an individual. One size does not fit all when it comes to hayfever and probing questions such as 'What time of the year do your symptoms start? What have you used before? What symptoms are different this year?'"
Angela Chalmers, pharmacy manager, Boots, Holloway Road, London

GlaxoSmithKline Consumer Healthcare

P

all-round non-drowsy relief of airborne allergy symptoms, including sneezing, itchy, watery eyes, nasal congestion/runny nose and a blocked up, groggy feeling. Can also be used to prevent symptoms

Aqueous nasal spray suspension containing 50 micrograms fluticasone propionate per spray

Once-daily, providing up to 24-hour relief from hayfever and other airborne allergies.

Known hypersensitivity to ingredients.

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Tel: 0845 762 6637

MSD

GSL

allergy and hayfever relief, non-sedating antihistamine

loratadine

A £1.6m summer multimedia campaign – TV, print, outdoor and online – from May to July. High profile media sponsorship includes the Sky News and Metro newspaper pollen counts during the peak hayfever season.

Possible side effects include drowsiness, headaches, increased appetite and insomnia in adults; headache, nervousness and fatigue in children.

www.clarityn.co.uk

Tel: 01992 467272

Church & Dwight UK

allergy, hay fever and rhinitis

drug and preservative free, Sterimar is a natural sea water nasal spray

Same concentration of salt as in the human cells for a gentle solution suitable for all – including pregnant women, children 3 years plus and people who cannot use traditional medicine.

www.freethenose.com

Tel: 01303 858821

Case study

PENFIELDS PHARMACY, WOLVERHAMPTON

Allergy UK accreditation

This is the second year we have been accredited to provide the Allergy UK pharmacy allergy screening service. We have patients travelling from up to 20 miles away for a consultation, which shows there is a need for this service.

Allergy screening consultations

We normally book appointments for consultations during our quieter time so it doesn't affect the running of the dispensary. The staff do the initial filling out of the screening form with the patient details before a consultation. We charge £35 for an initial consultation which takes around 20 minutes. In over 75 per cent of cases, I can deduce what is causing the allergy from the patient's history and symptoms and I suggest appropriate treatment.

Testing for allergies

If a patient needs (or wants) an allergy test as well as a consultation, we charge a further £25 for the test. Our staff are trained to carry out two different allergy tests with a finger prick blood sample. One test involves inhaled allergens and the other one is for food specific allergies.

Special promotions during May

We are reducing the cost of an allergy consultation from £35 to £25 for the month of May. We have produced eye catching posters to highlight the service and these will be in local GP surgeries and our own branches. During National Allergy Week [May 10-14] we will put a table out displaying all the allergy products together with patient information leaflets.

election countdown 2010

Twenty years

From the good (new contracts) to the bad (IT delays) via the ugly (increasing paperwork), governments have given UK pharmacists a bumpy ride over the last two decades, finds **Charles Gladwin**, in part one of the C+D Election Countdown

1990
- Launch of the NHS internal market and the era of competition

1991
- First NHS trusts set up

1992
- MCA (Medicines Control Agency, now the MHRA) streamlines POM to P switches

1994
- Audit Commission finds GP prescribing budget is being wasted
- Sunday Trading Act comes into effect

1995
- Disability Discrimination Act passed

1996
- NHS electronic network starts
- Local health authorities formed from FHSA (Family Health Services Authority) and DHA (District Health Authority) mergers
- DH publishes three white papers: Choice and opportunity; Primary care: delivering the future; and The NHS: a service with ambitions

1998
- The DH publishes A First Class Service
- NHS Direct launches

1999
- Nice set up
- PCGs (primary care groups) set up
- Devolution takes effect

2000
- NHS walk-in centres begin roll-out
- DH publishes the NHS Plan and the Pharmacy Plan

2001
- Morning-after pill becomes available OTC
- DH publishes Shifting the Balance of Power

2002
- PCTs set up
- National Programme for IT launched
- NHS Reform and Health Care Professions Act 2002 passed
- LIFT (local improvement finance programmes) pave the way for super-surgeries

His route to work may not have changed over 20 years, but community pharmacist Tim Cottingham says his work certainly has.

As an independent contractor in Grimsby, North East Lincolnshire, the first big change of the period was the start of needle exchange services in 1992. "I saw it as the first new service to have extra money attached," he says. The service's success lay in it being "a direct service to people who had not really had a service before then". It mushroomed into a supervised methadone service in 2000, and is now a mainstream offering.

One outcome for Mr Cottingham was that he set up Freelance Needle Exchange Ltd. Another was sexual health service development, partly as a result of people requesting the needle exchange service packs for the condoms they contained.

Patient group directions (PGDs) contributed further as the morning-after pill could be supplied without prescription. "That was very exciting and still is," says Mr Cottingham. "I find that the most challenging service as you do not know the story behind the request, and it is never clear cut."

Becoming expert

From needle exchange to PGDs, these service evolutions illustrate how pharmacy has changed. "Pharmacy always used to be black and white, but now there are more grey areas where we can make decisions ourselves," Mr Cottingham says. "We are the medicines advocate for the patient. We are in a better position to ask for something. Pharmacists can say to the doctor, 'There is a problem and we have a solution; are you happy with it?'."

Valerie Sillito, a community pharmacist working for Boots in Aberdeen, agrees. In 1990 she could not have envisaged she would go on to become an independent prescriber with a clinic at a GP surgery. "My job is far more interesting now," she says. "We were very much a supply function in those days. Now, the doctor will speak to you much more readily. We discuss things at a professional level and they expect you to phone."

More medicines, longer hours

In 1992 the Medicines Control Agency (now the MHRA) streamlined the switching of prescription medicines to OTC status. Ms Sillito remembers this as a "huge" step towards pharmacists developing a more clinical role. "We were being tested to make a decision," she says. Developments such as the minor ailments service added further to pharmacists' status in Scotland.

Greater availability of GSL products, self-selection in supermarkets, and the end of resale price maintenance also shifted public expectation, says Adrian Price. He heads up pharmacy services at the Co-operative Pharmacy and has seen the impact of the Sunday Trading Act of 1994, and extended trading hours. One problem has been matching this demand with the centralisation of GP out-of-hours service.

"It becomes difficult to justify running a pharmacy business on a Saturday and Sunday when there are no GP services, but this has to be balanced with providing access to pharmacy services," he explains.

Regulations and bureaucracy

Information governance is another bugbear. Besides the longer hours, Mr Cottingham worries that paperwork is becoming unmanageable. "I'm starting to believe that contractors like myself are a dying breed because of the number of things we have to do that are bureaucratic and not patient care-related," he says.

Noting changes in governance and professional regulation, Mr Price adds: "It is something pharmacists have always done, but it's the note-taking and record-keeping that is difficult, especially in a busy pharmacy." The single issue that had the biggest effect was Shipman, he believes. And while head office can put new processes in place, the

# of change

Twenty years of DH pharmacy ministers...

Virginia Bottomley
Brian Mawhinney
Baroness Cumberledge
Gerald Malone
Gisela Stuart
Hazel Blears
Lord Hunt
David Lammy
Rosie Winterton
Andy Burnham
Dawn Primarolo
Phil Hope
Mike O'Brien

... and health secretaries

The last three health secretaries: Patricia Hewitt, Alan Johnson and Andy Burnham

Kenneth Clarke
July 1988 – November 1990

Wiliam Waldegrave
November 1990 – April 1992

Virginia Bottomley
April 1992 – July 1995

Stephen Dorrell
July 1995 – May 1997

Frank Dobson
May 1997 – October 1999

Alan Milburn
October 1999 – June 2003

John Reid
June 2003 – May 2005

Patricia Hewitt
May 2005 – June 2007

Alan Johnson
June 2007 – June 2009

Andy Burnham
June 2009 – present

2003
- Tobacco advertising banned
- DH document Building on the Best flags up repeat prescriptions and more OTC medicines

2004
- First NHS Foundation trusts established
- Disability Discrimination Act extended

2005
- Control of entry exemptions come into effect
- New pharmacy contract for England and Wales comes into effect
- Nurse and pharmacist prescribing begins

2006
- SHAs and PCTs realigned
- New pharmacy contract for Scotland comes into effect

2007
- NHS Choices website launched
- Smoking banned in restaurants and pubs
- Lord Darzi's Framework for Action published

2008
- Lord Darzi's Next Stage Review published
- DH publishes the pharmacy white paper

challenge is to make them easy to use so that store level staff will incorporate them into daily practice.

NHS restructuring does not help, either. It is "something of an annoyance", says Mr Price, as PCTs take a couple of years to settle after each change. "We are now seeing [pharmacy services] moving on as there has been some continuity in the past two or three years, although this looks likely to change again."

Opportunities and practicalities

The new pharmacy contracts – which recognised healthcare divergence driven by devolution in 1999 – formalised what the profession had been developing, says Mr Price. "The high point is [that] the direction of travel is absolutely right and we are heading to a more clinical service. Care pathways and the like have taken the profession from moving tablet boxes around to providing clinical services."

As PSNC chief executive Sue Sharpe points out: "In the mid-1990s, developing awareness of pharmacy's potential to provide a greater role in care led to the PIANA initiative [the RPSGB-led Pharmacy in a New Age]. Little happened until the 2005 new contractual framework introduced MURs and health promotion services nationally."

Mr Cottingham sees the contract as an opportunity for more pharmacy input. For example, he recommends an MUR whenever a patient moves onto monitored dosage systems.

Ms Sillito tries to be enthusiastic, but says: "My big problem is IT. They promised us IT connections but where are they?" She also notes the knock-on effect in Scotland that the category M situation in England has had.

Health and safety has also changed practice. For example, extemporaneous dispensing has all but vanished, replaced with specials manufacturing. While there are benefits, it adds cost and can delay treatment.

The future

"Pharmacy has come an awfully long way over the past 20 years," says Ms Sharpe. "Strides have been made toward the realisation of [pharmacists'] full clinical potential. Where dispensing was once seen as the alpha and omega of the community pharmacist's role, 2008's white paper set a course to place pharmacy at the heart of the NHS primary care network."

As politicians of all colours tout their manifestos in the countdown to the general election, Mrs Sharpe has identified some priorities. One is the need to tackle barriers to development, including driving up commissioning standards across the board. She also wants to ensure that investment in pharmacy's future is sustained and consistent.

And, at the coalface, Mr Cottingham remains upbeat: "There's still a lot about pharmacy I love. It's still interesting."

"I see pharmacies playing a significant role in helping PCTs commission services"

Tory shadow pharmacy minister Mark Simmonds, p27

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WHERE NATURE MEETS SCIENCE

What the Conservatives would do for pharmacy

Zoe Smeaton talks to shadow pharmacy minister Mark Simmonds

election countdown 2010

Conservatives

Key Conservative health policies

The Conservatives say they will never change the idea that healthcare should be free at the point of delivery. The party says the most urgent task is to reduce the NHS deficit. It has also pledged to decentralise power, making healthcare staff accountable to patients. Pledges include:

- unleashing an "information revolution", making detailed data about the performance of healthcare providers available to the public online
- implementing a "payment for results" system throughout the NHS
- reforming the way drug companies are paid for NHS medicines so any cost-effective treatment can be made available through the NHS
- turning the Department of Health into a Department of Public Health and providing separate public health funding to local authorities
- giving GPs the power to hold patients' budgets and commission care on their behalf, and creating an independent NHS board to allocate resources and make access to the NHS more equal
- giving patients the power to choose any healthcare provider that meets NHS standards, and putting them in charge of their own health records, choosing which providers can see them
- reforming NHS Direct and giving patients access to a doctor or nurse when the local surgery isn't open.

Source: Conservative Draft Manifesto 2010

Mark Simmonds: pharmacists' interest must be aligned with other primary care providers

How do you think pharmacy has progressed since the white paper was published two years ago?

I think with greater central government support pharmacy could have developed additional services faster than it has done and I think that the implementation of the white paper has been too patchy and too slow. We need to find ways of ensuring the additional services that pharmacists could provide have the quickest impact on patients.

What extra services would you most like to see pharmacists delivering?

We think there are significant enhanced services that pharmacy could offer in addition to those they are doing at the moment and some of those were set out in the pharmacy white paper – such as MURs, long-term conditions, I think MURs need to go further than they do the moment – there's a strong argument for pharmacists to provide not just advice for patients but also to provide advice on an ongoing basis to GPs... to make sure patients are getting the appropriate drugs at the appropriate time. But it's not just the services that are already being done by many pharmacies, it is also things like sexual health. And I think there's a much bigger role that pharmacists can play in disseminating information to patients to enable them to make informed decisions.

How quickly would you want to see these extra services being delivered?

We would definitely want to put our foot on the accelerator and make sure that services, where appropriate, are being provided on the front line for the benefit of patients. One of the mistakes the current government has made is that they often talk about new services and new resources but often all they are doing is re-announcing what they have announced previously. They never actually get on and deliver it, so people have become extremely sceptical about the whole of the impact that central government can make. We would like to change that.

Would you involve pharmacists in commissioning?

I think pharmacy has a significant role to play in co-ordinating their work with others involved in primary care, primarily GPs. Under our proposals for GP-led commissioning, I see pharmacies playing a significant role in helping GPs commission the appropriate services while also providing some of the services where appropriate.

Would you incentivise GP commissioners to work with pharmacists?

If we're being honest I think that there are parts of the country where GPs and pharmacists do work

well together, but there are also places where there is friction and tension. If we're given the chance, what we must do is make sure that the interests of GPs and pharmacists are aligned to make sure that everybody is moving and working in the same direction for the maximum patient benefits and patient outcomes. That's something that I want to look at very closely.

So would you see a pharmacy quality and outcomes framework (QOF) coming in the future?

It's something that I'm prepared to look at. It's extremely complicated when you get into it, as C+D readers will be aware, but we do have to find ways of financially aligning the interests of everybody involved in primary care to make sure that everybody is moving in the same direction.

How would you fund extra pharmacy services in the future?

We have ringfenced the NHS budget but that doesn't mean we can't realign and refocus the funds within the NHS to maximise the benefits at the front line to patients. We think there's significant waste in the system. One waste is the level of administration and bureaucracy that exists and we would pledge to take one third of that out; that's a £1.5 billion saving. We're also going to have a radical look at the quangos, which again cost billions of pounds on an annualised basis, and many of them just duplicate what each other do. Certainly some of those monies we would see being refocused back into frontline patient care, some of which clearly would be allocated to the weight of pharmacies providing additional services.

What will happen to the NHS IT programme if you get into power?

We're not in favour of the centralised IT system, which we think has been an extraordinary waste of taxpayers' money; we're much more in favour of localised solutions as long as they have the ability for information to flow across those localised systems. The second thing to say is that we would like to see much more co-ordination between GPs and pharmacies in relation to IT systems so both professions can access patients' information as long as it's with the patients' permission.

What would happen to the electronic prescription service (EPS) under a Conservative government?

What has been disappointing about EPS is the slow take-up, but I think it is certainly something that should be encouraged.

Would you like to see single dispensing errors decriminalised?

I don't think progress has been quick enough on that. We would certainly like to see it decriminalised. We proposed amendments to the particular piece of legislation and the government said they would go away and look at it and haven't come back. This is certainly something we'd want to change quite quickly and we'd certainly consider inserting it into an early health bill that was brought before parliament.

Would you back a national PR programme to promote pharmacy?

We would prefer to see those sorts of initiatives done locally. I think they can have a much faster and better impact in a particular locality because your messages will depend on the type of patient groups you are trying to access. But I think we've got to have a much more sophisticated approach and try to find ways of taking healthcare messages to patients, rather than just waiting for patients to access healthcare. I think pharmacy could play a big role in that.

Do you support remote supervision?

I'm nervous about it, if I'm honest. We'll have to see how it works in practice, but it's something that I would want to be monitoring carefully.

How do you think drug shortage problems could be eased?

I'm quite concerned because clearly as the economy and public finances continue to deteriorate the pound is going to get weaker and the problem is going to be exacerbated. I think the government needs to get a real grip on the number of export licences they are granting but there also needs to be a much greater co-ordination between patients and those involved in the supply of pharmaceutical products.

Do you support the plans for PCTs to control pharmacy contracts using pharmaceutical needs assessments?

We understand that you can't go completely to a free market in the location of pharmacies and we think PNAs are, in theory, quite a good mechanism to ensure that all localities have the appropriate level of pharmacies. Where there are question marks is over how they will work in practice, because there doesn't seem to be enough progress, and whether the PCT is the appropriate place to have them. Under our public health agenda we will have directors of public health, who will be responsible for both the PCTs and the local authorities in localities, and that may be the right place to put PNAs.

So can you sum up your pharmacy policy for the next five years?

We see a significantly enhanced role for pharmacy in terms of providing services over and above what it has been providing at the moment. Also a much greater alignment of interests with others involved in primary care and a greater involvement in commissioning services alongside general practice.

Next week: **Mike O'Brien and what Labour would do for pharmacy with a fourth term**

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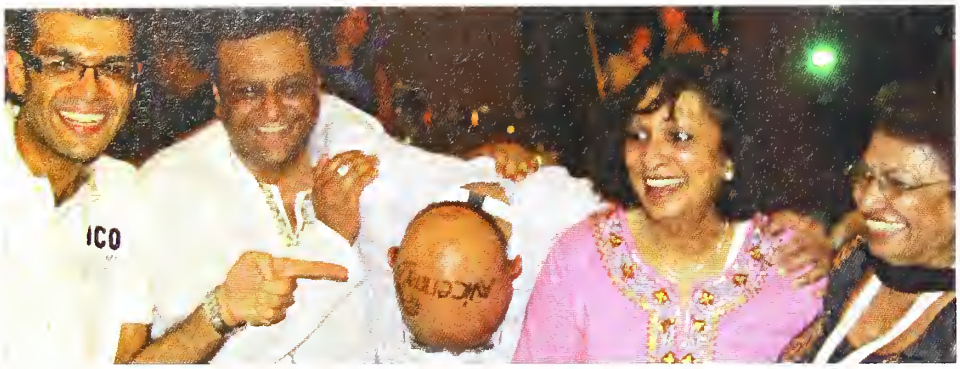
Postscript...

Win with C+D's Avicenna caption competition



Avicenna hit the beaches of India last week in a conference jam-packed with business sessions, Bollywood glamour and, er... beach volleyball.

The adventure didn't stop, from the moment the delegates arrived (greeted by drummers and an elephant) to the final, weary trek home. Those lucky enough to escape the April showers were treated to spectacles ranging from kathakali dancers (think a green mime with inflated trousers) and Bollywood dance routines to firework displays by tropical lagoons.

Of course, with temperatures soaring up to 35°C and sweltering humidity, it was inevitable a few delegates would get touched by the sun – which probably explains why London pharmacist Uma Patel decided to get the Avicenna logo henna tattooed on his bonce.

Despite the tattoo still being visible as Mr Patel returned to his Alphega pharmacy, he was rather pleased with his handiwork. So pleased that he's offering a bottle of his finest malt whisky to the C+D reader who comes up with the best caption to this photo.

To enter, send your caption to postscript@chemistanddruggist.co.uk by April 25. The best entry, as judged by Postscript, will get the booze.

C+D Recruit of the week

Meet Hannah Flynn, who joins the C+D team this week as a reporter

Why did you want to be a journalist? Because I like investigating things, finding out things, and speaking to people.

What's your background? I did a biology degree at Manchester University, and a journalism graduate course at Cardiff. My last job was production editor for a portfolio of energy magazines.

Who's your favourite author? Iain Banks. My favourites are The Wasp Factory and The Crow Road.

What was the last movie you saw? I Love You, Phillip Morris. It was good – Jim Carrey was funny. It was about a man who keeps escaping from prison to see his lover.

What band would you most like to see? I'd like to go back in time to see The Smiths. Not for Morrissey, but for Johnny Marr.

What's your favourite ice cream flavour? Probably chocolate. Just plain chocolate.

If you were given £1,000, what would you spend it on? A car. I'd quite like a Ford Ka, so I can drive to the supermarket or go on holiday.

Tell us a joke?
Knock Knock.
(Who's there?)
Doctor.
(Doctor Who?)
How did you know!
That doesn't work very well on paper, does it?

To say hello to Hannah, give her a call on 0207 921 8194 or email her at hannah.flynn@ubm.com. And don't forget to follow her on Twitter: @CandDHannah

The Victorian Pharmacist

"The weapon is neither offensive nor defensive, but will, no doubt, be popular at Christmas parties"

Sir,

The accompanying sketch shows the design of a pretty little apparatus known as Gasking's perfume pistol. The stock of the pistol is an india-rubber ball, which can be easily filled with perfume, and this, by pressure, is at once forced into a thin spray through a narrow tube in the glass barrel.

The weapon is neither offensive nor defensive, but will, no doubt, be very popular at Christmas parties this season. It is very cheap, and a great advantage of selling such apparatus is that they necessarily increase the consumption of the scents which they diffuse.

I would commend this device to all druggists, as it shall no doubt prove an excellent product for sale.

The Victorian Pharmacist's comments and illustration are from a review from C+D in 1868, when it was considered stylish to shoot perfume into your face. What's the strangest thing you've ever sold? Email postscript@chemistanddruggist.co.uk

The Avicenna conference in tweets

@ChemistDruggist: Sue Sharpe performs a mime of category M on stage. Wish I'd had my camcorder. Marcel Marceau, eat your heart out.

@ChemistDruggist: Delegates hit the dancefloor. Some chronic dad dancing going on but nobody cares – good times.

@ChemistDruggist: Sunset by lagoon. Beautiful colours. Nice end to the conference.

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Help men take control of their annoying pee problems

The launch of Flomax Relief brings you the first and only effective,[1] non-prescription drug treatment for BPH – a progressive enlargement of the prostate – in men aged 45-75,[2] giving you the chance to raise awareness of this condition and take a central role in its management.

BPH causes annoying pee problems in 1 in 4 men aged over 40,[3] ranging from a frequent urge to go to difficulty getting started. With time and without treatment, these problems can progress to severely affect a man's life.[3] Despite this, men with BPH tend not to seek help from their doctor.[3]

To tackle this problem, Pharmacy and Primary Care are joining forces. Men are now able, for the first time ever, to access an effective[1] drug treatment for BPH over the counter. For customers that fulfil the required criteria, pharmacists can make an initial 2-week supply (14 capsules) of Flomax Relief, followed by a further 4-week supply (28 capsules) after symptoms and side effects have been reviewed. Customers must be referred to their GP within the first 6 weeks, for confirmation of suitability for long-term treatment. Flomax Relief contains a tried, tested, and trusted active ingredient – tamsulosin, the UK's most widely prescribed drug treatment for BPH.[4]

about BPH and Flomax
supply protocol, go
.co.uk/hcp

Prostate. Reference: 1. Narayan P et al. Journal of Urology 1998;160:1701-1706. Flomax MR Summary of Product Characteristics. 3. Simpson RJ et al. British Journal of [illegible] 1994;41:499-502. 4. Department of Health. Prescription Cost Analysis [illegible] www.dh.gov.uk (Date accessed: 14 October 2009).

Flomax Relief® MR – Product Information. Presentation: Flomax Relief MR containing 0.4mg of tamsulosin hydrochloride in a modified release capsule. **Indication:** Treatment of functional symptoms of benign prostatic hyperplasia (BPH). **Dosage:** For men aged 45-75 years. For oral use. One capsule daily. **Contraindications:** Hypersensitivity to any ingredients of the product; a history of orthostatic hypotension; severe hepatic insufficiency. **Warnings and Precautions:** Men taking an antihypertensive alpha-adrenoceptor blocker should consult a doctor before taking Flomax Relief. In individual cases, a fall in blood pressure can occur. Do not give to a man who experiences postural hypotension. Consult a doctor before taking Flomax Relief if a man has heart, renal, or liver disease, uncontrolled diabetes, urinary incontinence, or has had prostate surgery. Do not supply Flomax Relief to a man whose symptoms are of less than 3 months' duration. Do not supply to a man who reports dysuria, haematuria, or cloudy urine, in the previous 3 months, or who has a fever that might be related to urinary tract infection. Do not initiate treatment in a man planning cataract surgery, or who has recently experienced blurred or cloudy vision not caused by a doctor or optician. If urinary symptoms have not improved within 14 days of starting treatment the patient should be referred to a doctor. Medical review is required for diagnosis of BPH: Patients must see their doctor within 6 weeks of starting treatment for assessment of their symptoms and confirmation to continue taking Flomax Relief long-term from their pharmacist. Every 12 months, patients should be advised to consult a doctor. **Adverse Effects:** *Common*: dizziness. *Uncommon*: headache, palpitations, postural hypotension, rhinitis, constipation, diarrhoea, nausea, vomiting, rash, pruritus, urticaria, abnormal ejaculation, asthenia. *Rare*: syncope, angioedema. *Very rare*: priapism. Drowsiness, blurred vision, dry mouth or oedema can occur. IFIS has occurred in some patients during cataract surgery. **RRP (ex VAT):** 14 capsules £7.65, 28 capsules £14.46 **Legal Category:** P **Product Licence Number:** PL 00015/0280. **Date of revision:** December 2009. **Further information available from:** Boehringer Ingelheim Limited, Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. **Date of preparation:** April 2010/FMX0215

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone).